

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

093089

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 8 7
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Ethel L. Andrews</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>March 22, 1985</i>		2b. HOUR 1:35 P.M.	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 27, 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Worcester</i>	
10. CITY OR TOWN OF DEATH <i>Pocomoke City</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartley Hall Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <i>Virginia Accomack Chincoteague</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>841 South Main Street 9999</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Birch</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nancy Merritt</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>231-54-9793</i>		17. INFORMANT ADDRESS <i>Thomas R. Andrews Chincoteague, Virginia</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 29, 1985</i> , to <i>March 22, 1985</i> , that (I) (we) last saw the deceased alive on <i>March 21, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Robert Allen</i>	DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/22/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Allen</i>	22e. ADDRESS <i>305 10th St., Pocomoke City, Md. 21851</i>		

23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	23b. DATE <i>3-24-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Chincoteague, Virginia</i>
24. FUNERAL DIRECTOR <i>Gene S. Selzer</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 29 1985</i>	
ADDRESS <i>Chincoteague, Va</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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088083

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 8 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alma Evelyn Atwood			2a. DATE OF DEATH MONTH DAY YEAR 3 17 85		2b. HOUR 9:30 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 18 1919		
6 AGE (IN YEARS LAST BIRTHDAY) 64 66 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.				
10 CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MD 13b. COUNTY Caroline 13c. CITY OR TOWN Federalsburg 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Box 156, Meadowbrook 21632						
14 FATHER'S NAME FIRST MIDDLE LAST Henry F. Poole			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Boyles			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 448-12-1252		17 INFORMANT ADDRESS Federalsburg, Md. Andrea J. Sommers, Box 156, Meadowbrook Park,		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulo Rupt Arter + DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) ASVD - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-20-83 , 19 83 , to March , 19 85 , that (I) (we) lost saw the deceased alive on 3-17- 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Federico Arthes		DEGREE		22c. DATE SIGNED 3-18-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Federico Arthes, MD		22e. ADDRESS 3 Bay Street, Berlin, MD 21811				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg, Caroline, Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Frampton-Hawkins Funeral Home, 216 N. Main St., Federalsburg				
25a. DATE REC'D. BY REGISTRAR APR 22 1985		25b. REGISTRAR'S SIGNATURE [Signature]				

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RECEIVED
JAN 10 1964
LIBRARY

One movie

Movie 2, 1964

Andrew J. Brown, Box 110, Leesport, Pa.
Leesport, Pa.

Director - Lehigh Valley Mall, Leesport, Pa.
Leesport, Pa. 18066
Leesport, Pa. 18066

086063

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kenneth Loomis Brown			2a. DATE OF DEATH MONTH DAY YEAR March 10, 1985			2b. HOUR P 8:30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 8 04		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD	
10. CITY OR TOWN OF DEATH Girdle tree		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bayview Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Advertising/Pharmaceutical		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Girdle tree		
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Franklin Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Bray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Bayview Road Golda Brown Girdle tree, MD 21829			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORME

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCT. 19, 19 84, to MARCH 10, 19 85, that (I) (we) lost saw the deceased alive on JAN. 26, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Allen W. Tustin, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. TUSTIN				22e. ADDRESS 32 Wesley Dr., Salisbury, Maryland			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-85		23c. NAME OF CEMETERY OR CREMATORY EastNewMarketCem.		23d. LOCATION CITY OR TOWN COUNTY STATE E. NewMarket, Dorch., MD	
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE	

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

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640420

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BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 09690

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth M Calloway			2a. DATE OF DEATH MONTH DAY YEAR 03 12 85		2b. HOUR 8:05a m
1. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10 22 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY At home
13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Mardela	
14. FATHER'S NAME FIRST MIDDLE LAST William Doyle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McHugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 181-10-9426		17. INFORMANT ADDRESS Mary Lee Whittington - 606 Meadowbridge Rd Towson, MD 21204	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAL ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) UNKNOWN

DUE TO, OR AS A CONSEQUENCE OF

(c) CONGESTIVE HEART FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 22, 1985</u> to <u>March 12, 1985</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Robert Allen</u>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/12/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert B. Allen, M.D.		22e. ADDRESS 305 10th st., Pocomoke City, Md. 21851	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>3/14/85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>	23d. LOCATION CITY OR TOWN <u>Mardela</u> COUNTY <u>Wicomico</u> STATE <u>MD</u>
24. FUNERAL DIRECTOR NAME <u>Bradshaw & Sons</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 15 1985</u>	25b. REGISTRAR'S SIGNATURE <u>Eda Davidson-Rendell</u>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				85 09691			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Marion Gilmore Coffey				2a. DATE OF DEATH MONTH DAY YEAR 3 21 85		2b. HOUR 11:15AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 99		6 AGE (IN YEARS LAST BIRTHDAY) 85 85 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10 CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home, Berlin, MD		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b KIND OF BUSINESS OR INDUSTRY Retired	
13a STATE PA		13b COUNTY Delaware		13c CITY OR TOWN Philadelphia		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Frederick Coffey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bender		13e STREET ADDRESS / ZIP CODE 1300 Lombard St., Apt. 1409 99999			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 209-12-1528		17 INFORMANT 508 Tony Tank Lane Betty Farlow Salisbury, Maryland 21801			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Age</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>83</u> to <u>March</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>March 21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Federico Arthes MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-21-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Federico Arthes, MD				22e. ADDRESS 3 Bay St., Berlin, MD 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/21/1985		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crem		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24. FUNERAL DIRECTOR NAME ADDRESS BAKER & BOUNDS SALISBURY, MD				25a. DATE REC'D. BY REGISTRAR MAR 26 1985			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

150100
% COTTON FIBER

MADE IN THE U.S.A.

086120

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 9 2

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hattie C. Ewell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-18-85</i>			2b. HOUR <i>3 A M</i>	
3. SEX <i>F</i>		4. RACE <i>Blk</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 20 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Snow Hill</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Worcester</i> MD.	
10. CITY OR TOWN OF DEATH <i>Snow Hill</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Forest Lane Rt 2 Box 37</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Worcester</i> 13c. CITY OR TOWN <i>Snow Hill</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>Rt 2 Box 37</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Howard Corbin</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Olivia Harmon</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>William Ewell</i>		ADDRESS <i>Same as Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>NUTRITIONAL FAILURE & ANEMIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>METASTATIC BREAST CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETES</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i> <i>1 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DIABETES</i>							
19a. DATE OF OPERATION <i>1977</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BREAST CANCER</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>JUNE 1984</i> to <i>MARCH 1985</i> , that (I) (we) last saw the deceased alive on <i>MAR 2 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (they) did not, view the body after death.)							
22b. SIGNATURE <i>Robert C. LaMar, M.D.</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/19/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert C. LaMar, M.D.</i>				22e. ADDRESS <i>104 N. Bay St., Snow Hill, Md. 21863</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>3-21-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St James Holiness</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Snow Hill Worc. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Jolley Memorial Chapel Salisbury Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>a Davidson-Randall</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

21

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085097

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stella Jones Holland			2a. DATE OF DEATH MONTH 03 DAY 11 YEAR 85			2b. HOUR 11:25a					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 02 DAY 22 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS HOURS 00 MIN. 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.					
10. CITY OR TOWN OF DEATH Pocomoke City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Virginia		13b. COUNTY Accomac		13c. CITY OR TOWN Assawoman		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 99999			
14. FATHER'S NAME FIRST George MIDDLE William LAST Jones				15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Birch LAST Birch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 228-44-8190		17. INFORMANT ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CEREBRO VASCULAR ACCIDENT**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-12 , 19 78 , to 3-11 , 19 85 , that (II) (we) last saw the deceased alive on 3-11 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) view the body after death.							
22b. SIGNATURE J. G. Santiano M.D.				DEGREE		22c. DATE SIGNED 3-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. SANTIANO M.D.				22e. ADDRESS 100 8th St. Pocomoke City Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-13-1985		23c. NAME OF CEMETERY OR CREMATORY Assawoman Cove		23d. LOCATION CITY OR TOWN Assawoman COUNTY Accomac STATE G.D.	
24. FUNERAL DIRECTOR NAME Nick				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 9 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR					
Eva Daisey Hudson			3			1			85			8:30 a.m.								
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
Female			White			MONTH DAY YEAR 5 11 96			88			YRS.			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
PA			USA						Worcester MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Berlin			Berlin Nursing Home, Rt. 3, Box 13												Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
MD			Worcester			Bishopville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			RT. 1, Box 118			21813					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST						FIRST MIDDLE LAST														
Robert Hudson						Elizabeth Truitt Hudson														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS								
NO						212-90-7887						Preston J. Daisey, Towson, MD								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio Resp. Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

ASVD.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Age.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
			HOUR A.M. MONTH DAY YEAR											
			P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			21g. COUNTY			21h. STATE		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from June 1984 to Feb. 1985, that (I) (we) last saw the deceased alive on Feb. 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						DEGREE			22c. DATE SIGNED					
Dr. Federico Arthes						MD			3-1-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS								
Dr. Federico Arthes						3 Bay Street, Berlin, MD 21811								

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. COUNTY			23f. STATE		
Burial			3-4-85			Bishopville			Bishopville			Worcester			MD		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Charles W. Hart, Salisbury						MAR 6 1985						Federico Arthes					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OFFICE OF THE
DIRECTOR OF THE
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CENSUS



POPE CO. LTD.

March 20, 1924

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE MADELINE LAST NELSON Mary Madeline Nelson		2a. DATE OF DEATH MONTH DAY YEAR 3-25-85		2b. HOUR 1 ¹⁵ P.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-12-06	
6. AGE (IN YEARS LAST BIRTHDAY) 78		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield	
14. FATHER'S NAME FIRST Charles MIDDLE H. LAST Somers		15. MOTHER'S MAIDEN NAME FIRST Lelia MIDDLE Lankford LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
17. SOCIAL SECURITY NO. 212-74-1941		18. INFORMANT Emily R. Wilson -		ADDRESS: 603 Clearwood Rd. Baltimore, MD 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>Jan 18</u> , 19 <u>85</u> , to <u>Mar 25</u> , 19 <u>85</u> , that (b) (we) lost saw the deceased alive on <u>Mar 19</u> , 19 <u>85</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Robert S. Reilly MD</u>		DEGREE MD		22c. DATE SIGNED 3/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Reilly MD		22e. ADDRESS Rt 3 Box 232 Snow Hill, Md. 21863			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/29/85		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	
24. FUNERAL DIRECTOR NAME Bradshaw & Sons		ADDRESS Crisfield, MD 21817		25. DATE REC'D. BY REGISTRAR APR 1 1985	
26. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "b" or "c", item 18 must be marked "a".

BP

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081021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 9 6

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LLOYD A. PUSEY			2a. DATE OF DEATH MONTH DAY YEAR 3 11 85		2b. HOUR 4:55 P.M.
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 3 99		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.		
10 CITY OR TOWN OF DEATH BERLIN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION Owner of a Restaurant SHEET METAL	12b. KIND OF BUSINESS OR INDUSTRY Trailer Park	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY WORCESTER	13c. CITY OR TOWN OCEAN CITY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RT. 1 BOX 311 21842
14 FATHER'S NAME FIRST MIDDLE LAST MATHEW PUSEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE PUSEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 05 7579		17 INFORMANT ADDRESS Irene P. Pusey, Ocean City, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Candida Rsp Curat</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pyel</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-</u> 19 <u>85</u> to <u>3-11</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-11-85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Federico Arthes</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHE, MD		22e. ADDRESS 3 BAY STREET, BERLIN, MD. 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-14-85	23c. NAME OF CEMETERY OR CREMATORY Christian		23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill Maryland	
24 FUNERAL DIRECTOR NAME Norman F. Dennis		ADDRESS Snow Hill, Md.		25. DATE RECEIVED BY REGISTRAR MAR 18 1985	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 showing any injury, or other traumatic event, the medical examiner must be notified.

BP

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Handwritten text, possibly a signature or name, located at the bottom center of the page. The text is written in a cursive or script style and is difficult to decipher due to fading.

099095

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for further advice.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 6 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elma Carlotta Smith			2a. DATE OF DEATH MONTH DAY YEAR 03 23 85			2b. HOUR 2106 P.M.			
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06 16 11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Worcester Co. MD.			
12. CITY OR TOWN OF DEATH Snow Hill		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		15. 12b. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Worcester 16c. CITY OR TOWN Pocomoke		17. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. 13e. STREET ADDRESS 1018 Lynnhaven Drive					
19. FATHER'S NAME FIRST MIDDLE LAST Charles T. Clark				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Gibbons					
21. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		22. 16b. SOCIAL SECURITY NO. 216-54-9666		23. 17. INFORMANT J. Avery Smith		24. ADDRESS 1018 Lynnhaven Drive Pocomoke City, Md.			
25. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Vascular Disease</u>									26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
27. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
28. 19a. DATE OF OPERATION		29. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				30. 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		31. 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
32. 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		34. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
35. 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		36. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
38. 22. I certify that (a) (this hospital) attended the deceased from <u>Nov. 23</u> , 19 <u>84</u> , to <u>Mar. 23</u> , 19 <u>85</u> , that (b) (we) lost saw the deceased alive on <u>Mar. 23</u> , 19 <u>85</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death.									
39. 22b. SIGNATURE <u>[Signature]</u>				40. DEGREE MD				41. 22c. DATE SIGNED 3/23/85	
42. 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Reilly MD				43. 22e. ADDRESS Rt 3 Box 232 Snow Hill, Md. 21563					
44. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		45. 23b. DATE 3/24/85		46. 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		47. 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Delaware			
48. 24. FUNERAL DIRECTOR NAME Scott S. Melson				49. ADDRESS Pocomoke City, Md.		50. 25a. DATE REC'D. BY REGISTRAR APR 1 1985		51. 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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